Part 7. Claim Status and Claim Correction

The status of nonpharmacy claims processed by MassHealth can be shown through the Recipient Eligibility Verification System (REVS) or on a paper remittance advice (RA). The fastest way to check claim status is through REVS.

The Claim Status subsystem within REVS allows you to verify the status of a claim submitted to MassHealth for services provided. This is conducted through the HIPAA transaction sets 276/277. Please refer to the appropriate REVS user guide on the Web at www.massrevs.eds.com for more information. Contact information for the REVS HelpDesk is found in Appendix A of your MassHealth provider manual.

For information about checking the status and correcting claims for retail pharmacy claims, refer to the *POPS Billing Guide*.

Correcting Claims

If a claim needs to be corrected, the method depends upon the status shown in REVS or the most current paper RA or electronic 835 RA. Review the following instructions before attempting to correct claims. Separate instructions are given for how to correct electronic claims and paper claims.

Please Note: References to "RA" refer to both the electronic 835 remittance advice transaction and the actual paper remittance advice, unless otherwise stated.

Suspended Claims

A suspended claim appears on an RA for information only. Claims are suspended for various reasons, such as for medical review or review of required documentation. Note in your records that the claim was received by MassHealth, so that it is not rebilled. You can track suspended claims by the transaction control number (TCN), since it will remain the same throughout the processing cycle. The claim will appear on a later RA as either paid, pending, or denied. Suspended claims require no action. Do not attempt to correct or rebill a suspended claim.

Denied Claims

Rebilling Denied Claims

When a claim is listed on the RA as denied, it has reached its final disposition. Review the error code(s) on the RA to determine the reason for denial. Refer to Part 6 of these administrative and billing instructions for an explanation of the error codes.

If the reason for the denial is correctable, follow one of the procedures described below.

- If the corrected claim will be received for processing within 90 days from the date of service, or from the date on an explanation of benefits (EOB) from another insurer, enter the corrected or new information on a new claim form, or follow the corresponding electronic claim specifications, and complete all required items. A clear, readable photocopy of the original paper claim form may be submitted. Send the claim and any required attachments to MassHealth as a new claim.

- If the corrected claim will be received for processing after 90 days from the date of service, or from the date on an EOB, but within 12 months from the date of service (18 months when an EOB is attached to the claim), you can submit it as a "new" claim unless one or more of the following conditions are present:
  - you are correcting the provider number;
  - you are correcting the member number;
  - you are correcting the date of service; or
  - you are correcting the service code and/or modifier.

Resubmitting a Corrected Claim

If you are correcting the date of service or the service code and/or modifier, follow the resubmittal procedures below.

For Electronic Claims

For instructions on how to address and correct claims submitted electronically using the void and replace transaction, review the applicable MassHealth companion guide for detailed loop/segment information.

For Paper Claims

Follow the instructions below. **Please Note:** A denied claim requiring a correction to the pay-to-provider Number, the member identification number (RID), or the invoice type cannot be resubmitted. If the corrected claim will be received by MassHealth within 90 days from the date of service, send it back as an original claim. If the corrected claim will be received by MassHealth more than 90 days after the to date of service or the EOB date, you may request a 90-day waiver (see page 5.7-4).

1. Resubmit only one claim line per claim form. Use a new claim form and enter the corrected or new information, or use a legible photocopy of the original claim and cross out all other claim lines.

   Exception: Inpatient hospital claims billed on the UB-92 must be resubmitted as an entire claim. (Outpatient claims are resubmitted one line per claim form.)

2. Enter an “X” in the Resubmittal box at the bottom of the claim.

   Exception: For claims submitted on the UB-92, enter "R" in Item 37 on Line A.

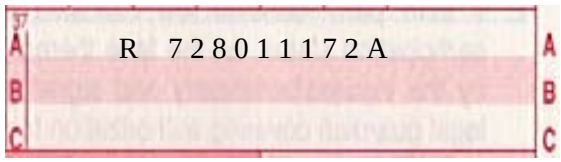
   Exception: For dental claims submitted on the ADA Claim Form, enter "R" in Field 35, Remarks.

3. Enter the 10-character TCN of the denied claim in the Former Transaction Control Number field at the bottom of the claim. The TCN is found on the RA where the claim was originally denied.

   Example: The following is an example of how to complete resubmittal information on a claim.

   Exception: For claims resubmitted on the UB-92, enter the original TCN from the denied claim following the “R” in Item 37 on Line A.

   Example: The following is an example is how to complete resubmittal information on a UB-92.



   Exception: For dental claims filed on the ADA Claim Form, use the Remarks section of the form. Enter the original TCN following “R” in Field 35. Justify all information to the left, and begin text immediately following the word “Remarks.”

   For all claims, including those submitted on the UB92 and the ADA Claim Form, that have been submitted several times, always enter the TCN of the original submission.

4. Attach any documentation that was included with your original submission and any additional documentation that may now be required to correct the claim.

5. Mail the completed form along with any required supporting documentation to the appropriate address listed in Appendix A of your MassHealth provider manual.

Requesting a 90-Day Waiver

You may request a 90-day waiver when you have exceeded 90 days from the service date or the date on an EOB from another insurer, the claim has never been listed on an RA in a paid status, and you meet one or more of the following conditions:

- you are correcting the member ID number;
- you are correcting the pay to provider number;
- you are changing the invoice (claim form) type; or
- you are billing the claim for the first time, and meet the criteria outlined in MassHealth regulations at 130 CMR 450.309 through 450.314. This includes retroactive member eligibility or provider eligibility.

If your claim meets the requirements for requesting a 90-day waiver, follow the steps below.

1. Prepare a new paper claim form. (All 90-day-waiver requests must be submitted on paper.)
2. Attach a copy of any RA where the claim has appeared, if applicable.
3. Attach any other supporting documentation, such as copies of self-pay notices.
4. Attach a cover letter stating the reason for the waiver request.
5. Do not enter resubmittal or adjustment information and do not enter a former TCN.
6. Mail the information to the address for 90-day waivers listed in Appendix A of your MassHealth provider manual.

The following circumstances do ***not*** require a 90-day waiver:

- claims that will be received within 90 days from the date on a third-party payer's EOB; or
- claims that can be resubmitted according to the instructions beginning on page 5.7-1, or claims that can be adjusted according to the instructions beginning below.

Paid Claims

Adjusting Claims

To correct or add information to a previously paid claim, submit an adjustment. An incorrect pay-to provider number or member ID number cannot be corrected by an adjustment. To correct these items, request a void according to the instructions for overpayments beginning on page 5.7-4 and submit a new claim using the correct pay to provider number or member ID. If necessary, request a 90-day waiver when submitting the corrected claim.

For Electronic Claims

Electronic claims may be adjusted by submitting void and replacement transactions. Consult the Provider Library at www.mass.gov/masshealth for the applicable MassHealth companion guide that details loop/segment information.

For Paper Claims

To correct information on paid *paper* claims, follow the adjustment procedures below.

1. Adjust only one claim line per claim form. Use a new claim form and enter the corrected or new information, or use a legible photocopy of the original claim and cross out all other claim lines.

   Exception: Inpatient hospital claims billed on the UB92 must be adjusted as an entire claim. (Outpatient claims are adjusted one line per claim form.)

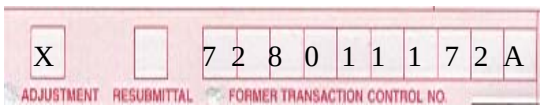
2. Enter an "X" in the Adjustment box at the bottom of the claim.

   Exception: For claims billed on the UB92, enter "A" in Item 37 on Line A.

   Exception: For dental claims submitted on the ADA Claim Form, enter “A” in Field 35, Remarks.

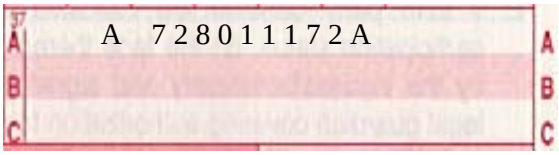
3. Enter the 10-character TCN of the paid claim in the Former Transaction Control Number field at the bottom of the claim. The TCN is found on the most recent RA where the claim appeared as paid or adjusted.

   Example: The following is an example of how to complete adjustment information on a claim.



Exception: For claims adjusted on the UB-92, enter the TCN from the most recent RA showing the claim as "PAID" or "CRADJ" (adjusted) following the "A" in Item 37 on line A.

Example: The following is an example of how to complete adjustment information on a UB-92.



Exception: For dental claims filed on the ADA 2002 or 2004 Claim Form, use the Remarks section of the form. Enter the TCN from the most recent RA showing the claim as "PAID" or "CRADJ" (adjusted) following the "A" for adjustment in Field 35. Justify all information to the left, and begin text immediately following the word "Remarks."

4. Do not subtract the original payment from your usual charge, and do not enter it in the Other Paid Amount column. (The claims processing system will perform the necessary calculation.)

5. Attach only documentation that was required with the original submission, if applicable.

6. Mail the completed form along with any required supporting documentation to the appropriate address listed in Appendix A of your MassHealth provider manual.

Voiding Claims

If you receive an overpayment that cannot be corrected by adjusting the claim, you must request that the payment be voided. If all payments on a particular RA need to be refunded to MassHealth, do not return the original check received from the State Comptroller's office. Instead, deposit the check and follow the void procedures outlined below.

Void requests are applicable when the full payment must be returned. The following are some common reasons for requesting a void:

- Payment was made to the wrong provider.
- Payment was made for the wrong member.
- Payment was made for overstated services.
- Payment for services was made in full by other third-party payers.

For Electronic Claims

For electronic claims, you can either:

- identify the claim(s) to be voided on a printout of the electronic 835 RA and attach a signed letter authorizing the void transaction(s); or
- fill out the Void Request form that is available for download from our Web site at www.mass.gov/masshealthpubs. No letter is necessary with this option. Send the RA printout and the Void Request form or signed letter to the appropriate address listed in Appendix A of this provider manual.

For Paper Claims

For paper claims, circle the claim line(s) to be voided on a photocopy of the RA and send the photocopy, as well as a signed letter or Void Request Form authorizing the void transaction(s), to the appropriate address listed in Appendix A of your MassHealth provider manual.

After the void request has been processed, the void transaction(s) will appear on a RA. The total amount originally paid will appear as a negative amount owed to MassHealth and will be deducted from subsequent payments until the full amount is recouped by MassHealth.

Requesting an Administrative Appeal

A claim received more than 12 months after the date of service (up to 18 months for those involving a third-party insurer and not more than 36 months when Medicare is the primary payer) will be denied. It may, however, be submitted for consideration as an administrative appeal when the criteria below are met. Note that a claim submitted after 36 months from the date of service cannot be appealed.

Criteria for Filing an Administrative Appeal

The provider must meet all of the following criteria.

- The claim must have received error code 888 (“The final billing deadline has been exceeded”) and the appeal must be filed within 30 days of the date on that RA.
- The claim must, as a result of a MassHealth error, have been denied or underpaid.
- You must have exhausted all available correction procedures outlined in these administrative and billing instructions, before the final deadline.
- You must have originally submitted the claim in a timely manner.

Accompanying Documentation

You must submit the following documentation with each claim for which you are requesting an administrative appeal:

- a statement that describes the MassHealth error that resulted in the denial or underpayment of the claim;
- a copy of each RA on which the claim has appeared, including the one on which the claim was denied with error code 888;
- any other documentation supporting your claim; and
- a legible and accurately completed paper claim form.

Requests for administrative appeals should be sent to the appropriate address listed in Appendix A of your MassHealth provider manual.

Assistance

If, after reviewing these administrative and billing instructions and applicable RAs, you still have questions about your MassHealth claims, you should contact MassHealth Customer Service. This department is available to respond to your written and telephone inquiries about claims that have not been processed correctly.

To inquire by telephone about a claim, call the MassHealth Customer Service number listed in Appendix A of your MassHealth provider manual.

- To inquire in writing about a claim, submit a cover letter describing the history of the claim, along with the following documentation to the appropriate address listed in Appendix A of your MassHealth provider manual:
  - a copy of the original claim;
  - a copy of each RA that pertains to the claim(s) in question; and
  - any other attachments that were required for the original submission, if necessary.